DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Physical Therapists
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 02-43 MAA
Issued: June 25, 2002

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 01-37 MAA
01-69 MAA

Subject: Update to the RBRVS* and Vendor Rate Increase for the Physical Therapy Program

Effective for dates of service on and after July 1, 2002, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2002 relative value units (RVUs);
- Additions to the Year 2002 Current Procedural Terminology (CPT™) codes;
- Changes to the Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes; and
- A legislatively appropriated one and one-half (1.5) percent vendor rate increase.

Maximum Allowable Fees

In updating the fee schedule with Year 2002 RVUs, MAA maintained overall budget neutrality. The 2001-2003 Biennium Appropriations Act authorizes this one and one-half (1.5) percent vendor rate increase for MAA fee-for-service programs. The maximum allowable fees have been adjusted to reflect the changes listed above.

Clarification

☞ MAA clarified documentation requirements for timed visits.

Attached are updated replacement pages 9-16 for MAA's Physical Therapy Billing Instructions, dated May 2000. To obtain this fee schedule electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedule link).

Bill MAA your usual and customary charge.

*RBRVS stands for Resource-Based Relative Value Scale.

Additional Coverage (Client 21 years of age and older)

MAA covers a maximum of 96 physical therapy program units in addition to the original 48 units only when billed with one of the following diagnoses:

- **Principal** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
890-897.7, 887.6-887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

Duplicate services for Occupational, Physical, and Speech therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).
[WAC 388-545-500 (11)]

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

If time is included in the CPT code description, the beginning and end times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028);
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039);
- Therapeutic exercises (CPT codes 97110-97139);
- Manual therapy (CPT code 97140);
- Therapeutic procedures (CPT code 97150);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530)
- Self care/home management training (CPT code 97535);
- Community/work reintegration training (CPT code 97537); and
- Physical performance test or measurement (CPT code 97750). Do not use this code to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).

The following are not included in the physical therapy program 48-unit limitation [Refer to WAC 388-545-500 (8)]:

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Checkout for orthotic/prosthetic use (CPT code 97703). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Muscle testing (CPT codes 95831-95834). One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Evaluation of physical therapy (CPT code 97001). Allowed once per calendar year, per client. Use CPT code 97001 to report the initial evaluation before the plan of care is established by the physical therapist or the physician. This is to evaluate the client's condition and establishing the plan of care.

- Re-evaluation of physical therapy (CPT code 97002). Allowed once per calendar year, per client. CPT code 97002 is for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This evaluation is for reevaluating the client's condition and revising the plan of care under which the client is being treated.

- Wheelchair needs assessments (CPT code 97703). One allowed per calendar year. Four physical therapy program units are allowed per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two physical therapy program units are allowed per assessment. Indicate on the claim that this is a DME needs assessment.

- MAA reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes 97601 and 97602. The following conditions apply:

  - ✓ MAA allows one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with one another.

  - ✓ Providers must not bill procedure codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Custom splints (cockup and/or dynamic) (State-unique procedure code 0002M).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy beyond that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits.

Limitation extensions (LEs) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services. For example: therapies are not covered under the medically indigent (MI) program.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instruction and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers are subject to post payment review.

In cases where the EPA cannot be met and the provider feels that additional services are medically necessary, the provider must request MAA approval for limitation extension. The request must state the following in writing:

1. The name and Patient Identification Code (PIC) of the client;
2. The therapist's name, provider number, and fax number;
3. The prescription for therapy from the provider. A letter describing the client's condition and the need for therapy is helpful;
4. The number of units and procedure codes used during calendar year;
5. The number of additional units and procedure codes needed;
6. The most recent therapy progress notes;
7. Copy of the physical therapy evaluation;
8. If therapy is related to an injury or illness, the date(s) of injury or onset of illness;
9. If surgery has been done, date(s) of surgery;
10. The primary diagnosis or ICD-9-CM diagnosis code; and
11. The reason why the client needs more therapy and why he or she is not independent in a home exercise program.

Send your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for additional physical therapy units for a client who has used 48 PT units this calendar year and subsequently has had knee surgery, would be **870000640** (**870000** = first six digits of all expedited prior authorization numbers, **640** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Physical Therapy(PT) LEs

PHYSICAL THERAPY

CPT: 97010-97150, 97520-97537, 97750

Code	Criteria
640	**An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has one of the following surgeries or injuries: 1. Lower Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation 3. Spine surgery
641	**An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-500(12)(13)]

- MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be arranged through the hospital.

Fee Schedule

☞ **Note:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	$17.06	$5.92
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	18.43	9.33
95832	Muscle testing manual	17.75	9.33
95833	Body muscle testing, manual	23.21	16.38
95834	Body muscle testing, manual	27.53	20.25
95851	Range of motion measurements	16.38	5.69
95852	Range of motion measurements	13.88	3.87
Modalities			
97010	Hot or cold packs therapy	Bundled	Bundled
97012	Mechanical traction therapy	8.42	8.42
97014	Electrical stimulation therapy	8.64	8.64
97016	Vasopneumatic device therapy	7.51	7.51

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97018	Paraffin bath therapy	$4.32	$4.32
97020	Microwave therapy	2.73	2.73
97022	Whirlpool therapy	10.01	10.01
97024	Diathermy treatment	2.73	2.73
97026	Infrared therapy	2.73	2.73
97028	Ultraviolet therapy	3.41	3.41
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	10.69	10.69
97033	Electrical current therapy	8.87	8.87
97034	Contrast bath therapy	8.19	8.19
97035	Ultrasound therapy	6.83	6.83
97036	Hydrotherapy	14.33	14.33
97039	Physical therapy treatment	6.37	6.37
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	16.38	16.38
97112	Neuromuscular re-education	17.06	17.06
97113	Aquatic therapy/exercises	17.97	17.97
97116	Gait training therapy	14.11	14.11
97124	Massage therapy	12.97	12.97
97139	Physical medicine procedure	9.78	9.78
97140	Manual therapy	15.24	15.24
97150	Group therapeutic procedures	10.92	10.92

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	$16.38	$16.38
97520	Prosthetic training	15.24	15.24
97530	Therapeutic activities	20.70	20.70
97535	Self care mngment training	18.43	18.43
97537	Community/work reintegration	15.02	15.02
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97601	Wound care selective	25.93	25.93
97602	Wound care non-selective	19.11	10.01
Tests and Measurements			
97001	Pt evaluation	41.63	37.31
97002	Pt re-evaluation	22.29	20.48
97703	Prosthetic checkout	16.15	16.15
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	15.92	15.92
Other Procedures			
0002M*	Custom splint (cockup and/or dynamic supply)	47.76	
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

*State-unique code

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.